

# Notice of Disability

## (Form and Notice Procedures)

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This form, including the “Procedures for Notice of Disability” section, is part of the *PEBB Initial Notice of COBRA and Continuation Rights* booklet. For more information about this form, the PEBB’s notice procedures, and your COBRA rights and obligations, consult the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, and other sections of the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. These documents are available by calling PEBB Benefits Services at 1-800-200-1004.

### When to use this form

You and your family may be entitled to receive up to an additional 11 months of continuation coverage, for a total of 29 months. This extension is available only for qualified beneficiaries who are receiving continuation coverage because of a qualifying event (the covered employee’s termination of employment or reduction of hours).

Use this form when the Social Security Administration has determined that a qualified beneficiary was disabled on any day within the first 60 days following a qualifying event due to the covered employee’s termination of employment or reduction of hours. **Note:** If the Social Security Administration made the disability determination before the covered employee’s termination of employment or reduction of hours, you may still use this form, so long as the qualified beneficiary remains disabled and you provide notice by the deadline described below.

### Deadline

The deadline for providing this notice is **60 days** after the latter of:

- The date of the Social Security Administration’s disability determination;
- The date of the covered employee’s termination of employment or reduction of hours; or
- The date the qualified beneficiary would lose PEBB coverage as a result of the termination of employment or reduction of hours.

Your notice of disability must also be provided within **18 months** after the covered employee’s termination of employment or reduction of hours.

**If your notice is late, or if it is not completed and provided to PEBB Benefit Services as described in the “Procedures for Notice of Disability” section, no beneficiary will be offered the opportunity to elect COBRA or other continuation coverage.**

# **Procedures for Notice of Disability**

## **How to provide notice**

Your notice **must** be in writing (using the PEBB form included in this notice) and either mailed or hand-delivered. Oral notice (in person or by telephone) and electronic notice (fax or e-mail) is not acceptable.

If mailed, your notice must be postmarked no later than the deadline described in these procedures. If hand-delivered, your notice must be received by PEBB Benefit Services at the address below no later than the deadline described in these procedures.

## **Where to provide notice**

### **Mailing address**

Health Care Authority  
PEBB Benefit Services  
P.O. Box 42684  
Olympia, WA 98504-2684

### **Street address (for hand deliveries)**

Health Care Authority  
PEBB Benefit Services  
676 Woodland Square Loop SE  
Lacey, WA 98503

## **Required form and information**

You **must** use the *Notice of Disability (Form and Notice Procedures)* form to notify PEBB Benefit Services of a qualified beneficiary's disability. All of the applicable items on the form must be completed.

## **Incomplete notice**

If you provide a written notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely only if **all** of the following conditions are met:

- The notice is mailed or hand-delivered to PEBB Benefit Services at the address specified in these notice procedures;
- The notice is provided by the deadline described in this document;
- From the written notice provided, PEBB Benefit Services is able to determine that the notice relates to PEBB coverage and a qualified beneficiary's disability;
- From the written notice provided, PEBB Benefit Services is able to identify the covered employee and qualified beneficiary(ies), and the date the covered employee's termination of employment or reduction of hours occurred; and
- The additional information and documentation necessary to meet PEBB requirements (as described in these notice procedures) is provided within **15 business days** after a written or oral request from PEBB Benefit Services for more information (or, if later, by the deadline for the notice of disability described above).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA or other continuation coverage will not be extended. If all of these conditions are met, PEBB Benefit Services will treat the notice as having been provided on time.

## **Who may provide notice**

The employee or former employee who is or was covered under PEBB coverage, a qualified beneficiary who lost coverage due to the covered employee's termination of employment or reduction of hours and is still receiving continuation coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA, PEBB Extension of Coverage, or Leave Without Pay (LWOP) coverage period due to the disability reported in the notice.

## Notice of Disability

Type or print clearly in black ink.

### Identify the employee or retiree who was enrolled in PEBB coverage

Print name of employee	Social security number
Print name of retiree	Social security number
Address of employee or retiree _____ _____	

### Identify the initial qualifying event

**Termination of employment**

**Reduction of hours**

**Leave Without Pay (LWOP)**

**Loss of employer coverage due to one of the following:**

- Part-time faculty member between periods of eligibility (see WAC 182-12-133(2)); or
- Employee reverted and was not eligible for employer-paid benefits (see WAC 182-12-141).

**Extension of Coverage**

**Loss of retiree eligibility due to one of the following:**

- Employer group terminated PEBB plan participation; or
- Retiree was determined no longer disabled by the Department of Retirement Systems and stopped receiving a retirement pension.

### Identify all qualified beneficiaries

Print name(s) of all qualified beneficiaries who lost coverage due to the initial qualifying event who are still receiving continuation coverage.  
\_\_\_\_\_  
\_\_\_\_\_

Is the address of each qualified beneficiary the same as the employee or retiree?  Yes     No    If different, provide address below:  
\_\_\_\_\_  
\_\_\_\_\_

(continued on next page)

## Identify disabled qualified beneficiary

Print name of disabled beneficiary

Is the address of each qualified beneficiary the same as the employee or retiree?  Yes  No If different, provide address below:

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## Social Security Administration's determination of disability

Date of Social Security Administration determination \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**A copy of the Social Security Administration's determination is required with this notice.**

Has the Social Security Administration subsequently determined that the qualified beneficiary is no longer disabled?  Yes  No

## Certification, signature, and date

**I certify that the above information is true and correct.**

I am the (check one):  Former employee

- Spouse
- Qualified same-sex domestic partner
- Dependent child
- Other (explain) \_\_\_\_\_

Signature

Date

Print name

Telephone number

(        )

Address

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### Please sign and date this form.

**Return to:** Washington State Health Care Authority, PEBB Benefit Services, P.O. Box 42684, Olympia, WA 98504-2684

Washington State law may require disclosure of any information you submit as a public record.  
The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at [www.hca.wa.gov](http://www.hca.wa.gov).

Visit our Web site at [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov)

### For HCA Use Only

Date notice of disability received \_\_\_\_\_ Date of postmark, if mailed \_\_\_\_\_

Social Security Administration determination enclosed?  Yes  No  N/A